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VASCULAR MOBILITY AND STASIS, INTERRUPTION, ARREST AND RESTORATION OF THE SANGUINOUS WAVE, PHYS- IOLOGICAL AND PATHOLOGICAL

BY THOMAS H. MANLEY, M. D., NEW YORK.

(Continued from last number.)

THE VASCULAR ELEMENT IN HEMORRHAGE.

So far in our consideration of haemostasis we have briefly touched on the haemic or morphological changes in the blood, which lead to a diapaedesis of the corpuscular elements or an elementary interstitial degeneration of them, and conditions which favor a transudate of the plasmic elements through the capillary wall; besides those imitations in the vascular torrent which often render hemorrhage difficult or impossible to subdue.

We will now turn to the vascular structures, in order that we may estimate the role which these tissues play in stopping the escape of blood.

At this stage it may be interesting

to inquire if it be probable that we may encounter pathologic states of the system, in which the blood is rich in plastic properties, while the vascular element in haemostasis is deficient. In answer to this question it may be necessary to here reiterate the primary proposition made when this series was begun, viz.: that the blood is a "vital current," and that it is inconceivable that a healthy state of a vessel can exist for anything more than a very brief period without fresh, invigorating blood to animate and nourish it. The fact is that the sanguinous and finer elements of the vascular system are so intimately related and reciprocally dependent on each other that one cannot survive without the other.

PHYSIOLOGICAL ANATOMY.

The sanguinous system is composed of two distinct and separate classes of vessels, both with respect to their situation and functions—the arterial and venous.

To these a third may be added—the capillary. The finer structural elements and the purposes which the arterial and venous systems subserve are nearly all no longer disputed questions; but not so with the capillaries. Histologists tell us that they are made up of a double plane of flat, endothelial cells, and that they are closed tubes. The former is by no means a settled question. After a long and careful study of the vascular current, through these minute paths, on the transparent tissues of the living animal, my own conviction is that their walls are lined by connective tissue corpuscles, the protoplasm of which is endowed with remarkable contractile powers. The blood corpuscles, red and white, readily pass in and out of them, and under various circumstances they are said to visibly expand and contract—a property certainly wanting in non-vascular endothelia. Stricker inclines to the view that the capillaries consist of a simple tunneling through the connective tissue stroma of the parts which they traverse.

This opinion, with my own observations, would seem to harmonize the antagonistic views held on this subject by Harvey and Riolan. The former believed and taught that the blood was discharged into the finer structures, the circulation duct there ending; the corpuscles by a species of attraction again coming together to enter the venous radicles. Riolan, the renowned Parisian anatomist and contemporary of Harvey, on the contrary, taught that the circulation was continuous from the finer arterioles into the venous capillaries, the view generally held to-day, though in its entirety most certainly a mistaken one. It is in the capillary that we have tissue metabolism and all those chemic and morphological changes which maintain life. Here the lymph system begins and great quantities of fluid pass and repass

from the gland epithelia, the lymph vessels and corpuscular bodies of the blood. As we observe the course of the blood approaching a capillary district it courses onward with an impetuous rush, to be brought almost to a standstill, as the almost numberless angles and spirals are reached.

Now commences the real work of animal chemistry. The arteries have performed their part when they have delivered the blood to the capillary areas. We must here leave the further consideration of the capillaries, which is practically of no importance in connection with the subject of haemostasis. It is true that we commonly hear of capillary hemorrhage, but a vessel cannot bleed which does not exist—as a complete vessel. In these instances the blood no doubt issues from the smaller arterioles and venous rootlets.

DISTENDED AND BLOODLESS ARTERIES.

During life in the human body the arteries are widely distended with blood, while after death or in the dying moments they send all their blood into the tissues.

This phenomenon is still enshrouded in great mystery. To say of it in explanation that the arteries send their blood into the veins is an error, for we find these latter vessels no more distended after death than we do before; in fact, many of the larger venous trunks are rather collapsed.

The ancients are said to have designated the efferent cardiac vessels "arteries" because after death they were found without blood in their lumina, and hence they were supposed to distribute air to the tissues. Now, all this may sound very well and seem plausible to any one ignorant of the literature of ancient medicine; but can any one for a moment suppose that many of those keen observers and eminent philosophers allowed themselves to be deceived by their own senses? On a rent or division of the deep tissues they saw with their own eyes that the arteries contained red blood, and we find incontestible evidence of

something more than an elementary knowledge of the circulation by the ancients in the works of Galen, Michael Servetus and their contemporaries.

But will not physiologists or some of our advanced scientists explain why the blood leaves the arteries when the vital forces of life succumb? It will not do to answer that it is caused by the contractions of the arteries, for the reason that after death they are as widely dilated as during life.

But the arteries, as a matter of fact, after death are not empty; they are not collapsed, but distended to their normal calibre by "air."

Where does it come from?

In a strict scientific sense, if the arteries were "empty" we would have a vacuum formed, and their walls would be closely collapsed.

THE ARTERIES AS CARRIERS OF BLOOD.

The arteries are a series of conduits, possessing marvelous energy, great tensile strength and remarkable resisting properties against trauma. They are always acting under high pressure and possess several characteristics and properties, some of which are capable of explanation by physical laws. They are high-

ly organized, having an independent, vascular and neural supply.

Their anatomical elements vary according to their capacity and situation, the larger having a thick supplementary layer of yellow elastic, fibrous tissue. The arteries are all deeply lodged or sheltered from violence and are encased in a sheathing of connective tissue, which is closely adherent to the outer tunic.

The blood is sent through them in a series of rhythmical jets, moving with great velocity, until its course is broken by the great number of angular branches into which they are finally divided.

If we regard these vessels from the mechanical standpoint alone, then it would seem rational, in the event of their rupture or division, we should proceed to close the rent and stop the leakage on mechanical principles. But when one has had anything like an extended experience with operative surgery or has conducted extensive experimentation on the lower animals' vessels, it becomes evident that the arteries possess in a large degree the property repair within themselves, a thorough familiarity with which constitutes one of the most important of acquisitions to the operating surgeon and practitioner.



BILIARY CALCULI.

(Continued from last number.)

Case reported by Dr. George E. Jones
before the Cincinnati Obstetrical Society.

GENERAL DISCUSSION.

Dr. Ransohoff: Mr. Chairman—The subject has been gone over so well, from all points of view, there remains very little to be said, and what I have to say will probably be in contrast with what has been said.

Now, in regard to the gall-bladder being a rudimentary structure, and, therefore, more prone to disease, we have many rudimentary organs which give no trouble, for instance, the hydatid of Highmore of the testicle, of which we hear little after we get out of the dissecting room. I doubt if we hear much of the pineal gland. The gall-bladder has a function. The mere fact that in the Cincinnati Hospital a contracted gall-bladder was found does not show that the woman did not suffer from gall stones, perhaps for many years. I am led to believe that the generally adopted view that women suffer infinitely more than men from gall stones is not true. I have recently had five cases and two of them were men; I have already operated five times upon men for gall stones. It is true, usually the gall stones are found in the gall-bladder, yet I recall one case very distinctly, presented by Dr. Withrow to the Academy of Medicine, in which the man had a stone in the common duct and another in the hepatic duct, and the largest was, I believe, in the hepatic duct.

In regard to the statement that gall stones developing in old persons must lead one to suspect malignant disease, or that there is a distinct relationship between malignant disease and gall stones in the aged is undoubtedly true; and yet I have seen many cases in which, because of the age of the patient, it was supposed a

malignant disease was present and an operation refrained from. The first gall stone operation I did was on an individual 76 years of age, who never had suffered at all until six or eight months before the operation, and yet had five large gall stones without any malignant disease. Quite recently I assisted Dr. Evans in a chole-cystotomy in a man aged 74, who had all the evidences of a grave icterus, in whom the tumor could not be distinctly felt, but a tenderness could be detected in the neighborhood of the gall bladder, and in whom the diagnosis was made of a probable malignant disease. In that case four or five gall stones were removed from the gall bladder, and there was no vestige of malignant disease.

The technical part described by the gentlemen to-night tallies with the general methods. I believe the operators, however, have not made a mistake by not making an ideal cystotomy. Opening the gall bladder, removing the stones and then dropping the gall bladder back into the cavity should not be done. I have never had the courage to do it. I know in many cases there has been no flow of bile for 12, 24 and 36 hours, and then the flow of bile comes on with a rush. If the stitches at that time were not firm and the gall-bladder in the cavity the end might come very quickly. I do not make the operation in two sittings, as do some. When one has a large gall-bladder to deal with the operation is certainly one of the simplest in surgery. There is nothing simpler than making a cholecystotomy if the gall-bladder can be brought into the wound. It is only when the gall-bladder is very small, when there

have been adhesions and one must operate through an incision; in a woman weighing possibly 240 pounds and only about four and one-half feet in height, that the operation assumes very great technical difficulties. I remember in one case we were certainly at the operation an hour before we could find the gall-bladder itself. In that case it was absolutely impossible to bring the gall-bladder into the wound at all. The Murphy button had not been devised, and I doubt if it would have answered. We packed the wound after operation and the patient recovered very promptly.

The Doctor asked whether there is ever any reason to remove the gall-bladder. I think there is. If we can do nothing with the gall-bladder and know the ducts are perfectly patent we are justified in removing the gall-bladder. Sometimes the gall-bladder is so soft and friable it is dangerous to leave it in the patient, and in such cases it should be removed, if for no other reason, to demonstrate what our friend here has said, that the gall-bladder is a useless structure.

Speaking of difficulties of diganosis, only in one of all my cases of gall stones have I ever been able to make a positive diagnosis before the operation by the passage of stones, and that was a case operated upon not long ago at the Good Samaritan Hospital. The patient had passed 14 or 15 stones. At the time of the operation, although we could feel the stones, we could not remove them. They disappeared under touch. The patient was retained in the hospital for about two months, and he has had no attacks since. The feces have been washed and no stones found. Very few surgeons have many cases without some mortality. When we speak of the fatality we must divide the cases into two kinds: 1. When the stones are in the gall-bladder or cystic ducts the cases ought to get well. 2. But when the stones are in the ductus communis choledochus, perhaps 30 or 40 per cent. of the cases will die. The facility of the operation is not here nearly so great. Worse than all, we are dealing here

with a region in which we have some blood vessels of very significant size, the wounding of which, while it may not be immediately fatal, certainly produces a degree of hemorrhage that is very alarming. In one case I was fortunate in finding the gall stones in the ductus communis choledochus, but it was impossible, because of the oozing, to remove them. I packed the wound, and after 24 hours was ready to remove them, but I removed them then without the patient's knowledge—for he was dead. I have had two cases of stone in the ductus communis choledochus, one in a man and one in a woman, both of whom recovered. The question of asantomosis between the gall-bladder and intestine is one with which I have had no practical experience. I think it would be better to resort to the plan which originally led to the bringing of the bile into the intestine as a secondary operation. The operation of cholecystenterostomy was really an operation which was devised to overcome fistula of the gall-bladder that would not heal. Right here I might say I was interested in the remark made by Dr. Jones in regard to his case, that he had allowed the fistula to remain open a considerable length of time. I know I have allowed some cases to remain open for the simple reason I could not get them to close. That is one of the banes of cholecystotomy. When we come to the turning of the bile into the intestinal canal I believe it is safer to make the operation in two sittings. When it is impossible to know an obstruction will be relieved I think it is wiser to establish an ordinary fistula, and if that will not close of itself—in other words, if the obstruction in the ducts is not overcome—it is better later to turn the bile into the intestinal canal. You know, Mr. President, operations upon patients who are jaundiced are very often fatal. The operation, then, so far as its gravity is concerned, is very different from that in a patient who is not jaundiced. The less we do in the jaundiced individuals, except to give immediate relief, the better it is for those individuals. We had better give the pa-

tient an opportunity to recover from his jaundice before resorting to a grave operation.

Dr. Dunning, of Indianapolis—Mr. Chairman: I did not purpose saying anything upon this subject to-night, and, besides, I believe there is little left to say, since the subject has been so thoroughly discussed. But as to diagnosis, I believe it has not been clearly enough shown that there is a possibility of differentiating an obstructed gall-bladder from a floating kidney. It seems to me we ought not very often mistake one for the other. If we remember the distended gall-bladder always rises and falls with respiration, and that nothing can hinder this unless some force is applied to the gall-bladder, and that the movable kidney may be moved so far away from the under surface of the liver and the diaphragm that it will not be in any way influenced by respiration. This is a practical point of very great value in differentiating between these two morbid conditions. I have been enabled several times to demonstrate a floating kidney when a distended gall-bladder has been thought to be the trouble. The best position for the patient in examining for distended gall-bladder is upon the back, the thighs flexed upon the trunk, the abdominal walls relaxed. Then we can take hold of the fundus of the gall-bladder, and if the patient takes a long inspiration the descent of the gall-bladder and liver can be accurately determined. It will recede again during expiration. If the patient is put on the side, if there is a floating kidney, we can push the kidney far beyond the edge of the ribs and imprison the kidney by pushing the other hand between the kidney and liver, depressing the wall so there is no movement of the kidney during respiration. Now, in the matter of diagnosing gall-bladder trouble and differentiating between that and malignant disease, I have considerable feeling, having several times made incisions for supposed distended gall-bladder and found malignant disease. In one instance I found a malignant disease extending up into the liver, and in another instance I found a nodule

which so nearly resembled the gall-bladder that I thought that organ was involved. I think I made a mistake in both these instances in operating when there was absence of the characteristic pain. I believe I would not operate again unless that pain were present. I think no matter how distinct a tumor we may have, no matter if it is in the region of the gall-bladder, if we have the pain absent we should refrain from operating. In the two instances in which I operated and found cancer there were extreme jaundice and hemorrhage. The hemorrhages had been present for some little time before the operation. I believe we may conclude from the study of cases that hemorrhage with jaundice is more frequently present when there is malignant disease than when there is simply jaundice from distended gall-bladder. I believe, as Dr. Ricketts has told us, every man must be his own judge when it comes to operating. I never did the ideal operation, yet once opened the common duct behind an impacted stone and took it out. In that instance the walls of the duct were so thick I thought the operation simpler than attempting to crush or remove the stone from above. The patient made a good recovery. In another case I was unsuccessful in removing a stone at one sitting, but succeeded subsequently. In that instance we have now intermittent closing of the common duct and the fistula remains open. Possibly some stones were left behind and there may be a re-accumulation.

I am very much pleased I am able to be present to-night, and thank you for the courtesy accorded me.

Dr. Dandridge:

Mr. President—I have had so very little experience in this branch of surgery I do not believe I can contribute anything.

Dr. Reamy:

I have seen several cases that have gotten well without operation. I only mention that in contrast with the expression of my friend. I do not mean by that an operation is not justifiable or ought not to be done, but I simply want to call at-

tention to the fact it is not always necessary to operate at once.

Dr. Rufus B. Hall:

Mr. Chairman and Gentlemen—I quite agree with the remarks of one of the speakers, that we should divide these cases into two classes, one the cases in which the operation is performed upon the gall-bladder and the other class those operated upon the common duct. The doctor will remember this subject was discussed at the Academy a few months ago, and then I said I thought the mortality following the operation of removal of a stone impacted in the common duct, when the patient is markedly jaundiced, five to eight or ten weeks duration, was more than 50 per cent. The doctor at that time thought 30 per cent. or 40 per cent. would cover the mortality. I will grant that will cover the reported cases, but when we take into consideration that many operators report their fatal cases last or not at all, and in many neighborhoods there are unreported cases of fatal operations, especially the fatal cases the operations upon the common duct, I am fully convinced the mortality is 50 per cent., if not greater, following operation for removal of stones impacted in the common duct. From this we can draw a practical lesson, which was emphasized by the speaker, that we should do incholemic patients as little surgery as possible. We must give the patient the best chance possible. Do not do a long operation when you can unload the patient by making a fistula, and then, if necessary, make a secondary operation to close the fistula, when he is practically a well man. The second lesson is that a large number of patients suffering from stone in the common duct have suffered for a long time, years and years, and finally jaundice comes on and after several attacks there comes the desperate one, and after the jaundice has continued for a number of weeks and at almost the last they consent to an operation. The lesson to be gained from this is a practical one. The patient known to be suffering from gallstone colic year after year should be operated on before the

stone is driven into the common duct. They should be operated on while the stone is still in the gall-bladder before they do have jaundice. In other words, I believe we could make a working rule something after this: If a patient were known to have gallstone, and the suffering is of such a character as to demand relief, after several attacks lasting over a number of months, then advise operation and do not wait until the stone is forced into the common duct, converting the case from one in which 98 per cent. recover to one in which fully 50 per cent. die.

In reference to the case reported by Dr. Jones, I remember seeing the case in the wards of the hospital and examining it hurriedly. While visiting another patient at the hospital the doctor asked me to come in and see that case. I rather considered that a compliment and did not regard my visit as a consultation or know that I was expected to express an opinion. In answer to a question, I said in a laughing way, "Doctor, I believe I would cut the patient in front." I did not say what I thought it was, I did not make a diagnosis, but I said I would cut the patient in front because the diagnosis was so uncertain. I do not know what I would have done if I had had the case to consider and operate upon. Possibly I would have made the incision in the back. But as it is I think the Doctor does not owe us any apology, for if all our cases of gall-bladder operations do that well we should be satisfied.

Dr. Julia Carpenter:

As to the medical treatment of non-surgical cases there are two points to which I would like to refer. The first is concerning the treatment during the attack, and the second concerning the treatment between the attacks. A brief statement of a case will illustrate these two points.

Nearly three years ago I was called to a case of very extreme colic from gallstones. The patient said: "Can you not relieve me without a hypodermic? I have so many attacks and am so sick from the morphine for several days following that I

dread that sickness almost as much as the pain itself." I replied, "If you have the patience to endure the pain we will try something else first." I then gave him ten grains of phenacetin, which brought some relief. In ten minutes the dose was repeated and the pain grew still less. Three antikamnia five-grain tablets were then given ten minutes apart. By that time the pain had almost ceased, the patient fell asleep and that ended the attack. In a few days he was about again, and was most grateful for having escaped the several extra days of sickness from the morphine.

I inquired whether he was sure the trouble really was gallstones and whether any had ever been found. He replied he had had several physicians and each one had diagnosed gallstones, but no one had ever told him to search for them. I then explained to his wife the process of searching for them, viz: To have the evacuations diluted with water and strained through cheese cloth. The result was there were found three small, pure white stones, each one having the appearance of a two-grain oval quinine pill. They pulverized easily and had the exact appearance of white cholesterin crystals.

In a few months he had another attack and the same treatment relieved him. In nine months more he again had an attack, but the same treatment did not relieve him sufficiently, and I followed it with a hypodermic of one-eighth grain of morphine with atropine, when the pain ceased entirely. No nausea followed the morphine and the same speedy recovery ensued.

The point of interest is that morphine is not always necessary to relieve these cases, and when the other remedies are not sufficient, still if used first less morphine is required and the dreadful sick stomach that follows its use can be avoided.

As to the medical treatment between the attacks there is a method that has not been mentioned, with which I have apparently had success. That is the systematic irrigation of the bowels with at least two quarts of water twice a week. In the case

mentioned a year has now passed since the patient had an attack and before using that method, for a number of years, an attack occurred every few months. This treatment, I believe, has had considerable to do with the good result.

Dr. Edwin Ricketts:

Mr. President and Gentlemen—The first patient I operated upon was a lady 63 years of age. In that case the stones were found in the common duct. Already I have had five cases in which undoubtedly there were calculi, in one case 28 grains of stone in the common duct, in another case two stones in the common duct. In the case of 28 stones they were in the common duct as well as in the gall-bladder. One thing as to the stones permanently engaged in the common duct. I do not think anybody ought to attempt to do anything in gall-bladder surgery without a pair of ligature forceps, for by introducing them and then opening them they dilate the gall-bladder wall, which we must remember can be stretched, and by the use of these forceps we can in this way extract the stones easier than in any other way. In a case operated upon last May I used the Murphy button. That is the extent of my experience with that instrument. The patient since that time weighs about 25 pounds more than she has weighed for years. The button was passed the thirteenth day. But the greater number of these cases are treated by the old-fashioned cholecystotomy.

Dr. Bonnifield:

I have very little further to say, Mr. President. As I said when I reported my case, I was unable to discover any cause for obstruction in the common duct, but as my patient was old and very weak, this exploration was not as thorough as might have been. The cystic duct certainly was not dilated. I could see the opening of the duct and could feel it very distinctly with my finger, and I could trace both ducts through their whole course and could discover no cause for obstruction. So I hope in time the obstruction will pass away. I telephoned

Dr. Mitchell to-day and he said the patient was still discharging a large quantity of bile, but he said she had gained considerable in health. In regard to Dr. Dunning's remarks, as to the ease with which we can diagnose between floating kidney and gall-bladder, I agree with him we can. But there is such a thing as a misplaced kidney, not necessarily movable, and in such cases the differential diagnosis may be very difficult.

Dr. Wenning:

The first point I would like to answer is the one raised by Dr. Eichberg as to the absence of the biliary matter in urine. I cannot vouch for that case, but that was the history given me. I question very much whether that was the fact. I do not know whether chemical examination previous to the time that the diagnosis of cholelithiasis was made.

Now as to the intermittent fever. At the time that the pains came on the patient evidently had more fever at night than in the daytime.

As to the remarks made by the other gentlemen, I would like to take exception to the complete ruling out of cholecystotomy by Dr. Ricketts. I think his remarks are too sweeping. If it is simply a useless organ, I cannot see what good can result from leaving a badly diseased gall-bladder in the body. In the great majority of cases cholecystotomy is indeed a safer operation than cholecystectomy and if the normal functions can be restored, with patency and diet, it is the only justifiable operation. But when the function of the gall-bladder is destroyed and there is a constant liability to recurrence, cholecystectomy is undoubtedly the ideal operation. There is no reason why, with proper precautions and in skillful hands, the mortality from cholecystectomy should be any greater than that from cholecystotomy.

Dr. Schoolfield:

In regard to the differentiation of distended gall-bladder from movable kidney, I have a case in my mind in which three as able diagnos-

ticians as ever were members of this society made a mistake in diagnosing a case as distended gall-bladder, which turned out to be a floating kidney. With each respiration the tumor came down and could be felt. There was jaundice, there were periodic attacks such as we have in gallstone colic, and also the respiratory projection of the tumor. I have had the lady under observation about three years and during almost all that time I have treated her for gallstone colic. She has had repeated attacks of jaundice from pressure, but within the last two or three months I have been able to make a very distinct diagnosis of floating kidney. The kidney has enlarged and come down low enough to enable me to get between the kidney and the diaphragm. But this case shows it is not always easy to make a differential diagnosis between distended gall-bladder and floating kidney.

In reference to cancer occurring in persons with gallstones, particularly old persons, I do not think the age of degeneration produces the cancer simply coincident with gallstones, but the gallstone itself, by causing irritation, is the original factor in producing malignant disease. I think also, as Dr. Ranschoff has said, on those cases of obstruction of the gall duct in which there is extreme jaundice, if we make a cholecystenterostomy, it is best to do it secondarily. The danger of operation with extreme jaundice is certainly very great, and it is much better to make a fistula to relieve the jaundice and afterward do a cholecystenterostomy if necessary.

Dr. Edwin Ricketts:

I do not think the Doctor understood me in regard to the cylinder of Murphy, about which I spoke. It is a cylinder about four or six inches in length, in which there is a button that can be fastened at the bottom of the cylinder, and then it can be packed around from bottom to top. The cases I think are better treated in that way than with cholecystectomy.

LA FOLIE EROTIQUE.

BY B. BALL, PROFESSOR IN THE UNIVERSITY OF PARIS.

Translated from the third French edition by F. E. Chandler, M. D.

(Continued from last number.)

III.

OBSCENE FORM.

The obscene form of sexual excitation is found in persons whose language, attitudes and gestures are constantly lascivious; but the physical condition does not correspond to this purely physiological excitation.

These persons who boast of their vice are almost always absolutely impotent.

These phenomena are common in general paralytics, in some old men and in a large number of raving maniacs.

Speaking in a general way, we may say that there is lack of co-ordination between the cerebral and genito-spinal centres.

In the natural order of things the sexual desires lessen with advancing age and an equilibrium is established between two opposite poles. This is the natural course and does not disturb either the physical or mental health.

In those who, in spite of extinction of the sexual power, still keep cerebral excitations that correspond to lost functions, it is quite a different matter.

As J. J. Rousseau puts it, "the wish still speaks when the senses have ceased" (*la volonté parle encore quand les sens se taisent*). These persons often try to remedy this state of things by the use of noxious drugs, and their mind is troubled by senseless preoccupation that can never end in normal satisfaction.

There are also patients who, without being impotent, talk so vilely that it can be attributed to nothing other than a state of insanity.

This tendency is often met with in the insane, especially in women with

hysterical insanity or puerperal mania.

IV.

THE EXHIBITIONISTS.

We must now mention those persons to whom Lasegue* gave the name of "Exhibitionists."

Without being impotent, these individuals, who are sometimes young men, take a strange pleasure in exhibiting their genitals to the gaze of women and children.

One of these persons may hide behind the columns of a church and scandalize the women at their devotions.

Another waits in the hall of an apartment house until some young girl passes, to whom he may exhibit himself in an indecent attitude.

A third chooses the frequented paths of our public parks to offer an obscene spectacle to the chance passer-by.

In this way they lay themselves liable to heavy penalties without the shadow of any enjoyment, and certainly nothing but insanity could cause an apparently well-educated and well-bred man to behave in such an idiotic fashion.

We have now in the "Clinic" a patient who may be considered as a classic type of exhibitionist.

It is a man 35 years old, of medium size and intelligence.

He commenced masturbation in his 9th year. When 18 years of age he was arrested and sentenced to imprisonment for three months because in the open street he showed his genitals to ladies who were passing.

After his release he returned home, where one day his father caught him masturbating during dinner.

*Lasegue, *Etudes médicales*.

Since then he has several times been arrested for "exhibiting" in the streets with absolutely no provocation for this senseless and stupid act.

After his last arrest he was sent here to us.

Conduct of this kind can show nothing if not insanity. These actions are so utterly wanting in common sense and intelligent reasoning that we can give the patients no other excuse.

V.

NYMPHOMANIA.

We have described the three principal varieties of sexual excitation. We shall now commence another subject.

The word "nymphomania," as generally used, indicates erotic fury in women; the word "satyriasis" designates the same in men. Trelah, using these definitions classed among the nymphomaniacs the woman whose history I gave you in our last lecture.

This, however, is a grave error. We should reserve the word "nymphomania" to designate a severe affection resulting from a lesion of the genital organs or of the nervous centres; we may distinguish two kinds.

The chronic form, less dangerous, manifested principally by an exaggerated sexual excitation.

The acute form, often accompanied by fever, is of quite another prognosis; its progress is rapid and usually ends in dementia or death.

An essential characteristic both of nymphomania and satyriasis is the impossibility of satisfying the patient's desires.

It is here no question of a physiological storm that clears up after the shower, but we have to deal with a permanent irritation that results from an anatomical lesion. The desires provoked by cantharidial poisoning would be fairly typical of this condition.

Nymphomania in women is often febrile and characterized by a great acceleration of the pulse, which may reach as high as 150 beats a minute. Death may supervene rapidly.

In addition to the lesions produced

by the congestion of the genital organs, the autopsy shows us thromboses of the sinus and lesions of the meninges (especially of the dura-mater).

We can cite several observations that are absolutely conclusive, although we regret that the details relative to the autopsies are either omitted or incomplete.

A woman, mother of a married daughter, showed for some years an aversion to marital relations.

Later on, she was taken with violent attacks of asthma, and nearly died. Helwich* suspected that they indicated in some unknown way the beginning of an attack of erotic insanity. "In fact," said he, "I could not pretend ignorance of the reports about town as to her venereal appetites. She herself told me frankly, but without coarseness or obscenity, with what ardor she sought those amorous assaults that she had so long repelled.

She also told us, with the greatest exactness, but in modest language, and without indecent gestures, of the fire that tormented her. *Hiat vagina, quasi patratorem nervum cupide admissura et amplexura; clitoris aestuat, erigitur, intumescit.*

Besides this, she complained of weight in the hypogastrium and of pruritus of the external genitals. Her conversation was almost entirely free from anything abnormal.

Later on, this disease grew worse and presented all the phenomena of the highest degree of hysteria. This was soon followed by death.

Examination of the womb showed four excrescences in the shape of a small kidney. Two of these contained a small cavity that did not communicate with the uterus.

These protuberances were on the base of the organ and were leaning against the vertebrae. On the same side, vesicules were seen on the ovaries. Incision of those vesiculae furnished about half an ounce of a black, gelatinous material.

In the cases of nymphomania reported by Louyer-Villermay there is

*Helwich, *Ephemerides naturae curiosorum*, Obs. 148, p. 308.

one that is particularly remarkable.

There was a young lady who cared equally little for the companionship of men or of her own sex. She was sad and given to dreaming. (Was she an onanist? Tr.)

When 30 years old she became more melancholy and subject to hysterical attacks, leaving the house only to attend church, and her father confessor, a man of advanced age and good reputation, was her only society.

Shortly afterward she had a pruritus on her entire body, but most pronounced on her face, which had been covered with boils for some time. To cure this furunculosis she had used bitter-sweet, milk, whey and warm baths.

Soon after this she lost her appetite and noticed a great moral and physical change in herself. Her eyes were more brilliant than usual. Up to this time she had always spoken sensibly and used good language, but one saint's day she went early to see her confessor and acted indecently and made shameful and lascivious proposals to him. He sent her back to her parents, who wished to give her a female attendant, whom she refused, saying that she had always detested persons of her own sex. At noon of the same day she was found stretched out on the ground, face downward and with disheveled hair. Later she was found in a chair, with her face red, her eyes shining, her pulse beating irregularly and rapidly; the hypogastrium was slightly swollen and tender on pressure. In reply to some questions asked her she threw a cup of lemonade into the face of her questioner.

Half an hour later she screamed and then recited the third strophe of the "Ode to Priapus." In my presence, said the attending physician, she rushed upon the male nurse that had been procured for her, begging him in the plainest language to immediately satisfy her passions, and threatening to assassinate him if he refused.

She was then bled with difficulty, because she refused to take any medicines.

Her spiritual adviser now endeav-

ored to calm her, but she immediately sprang out of bed, naked as when she was born, and in a terrible voice begged him to satisfy her lust, saying that she had always preferred priests.

Her hands were now tied and the curate commenced to exorcise her. She soon fell asleep and her genitals discharged a vile-smelling liquid. This calm was attributed to the exorcism. The pulse became slower and the hypogastrium less tense; her face was covered with perspiration. The patient seeming insensible, as many as 13 leaches were placed on her vulva and she was then put in a cold bath for two hours.

During the night she seemed comparatively quiet, but she muttered continually. Her pulse was weak and her respiration difficult. She carried her hand toward her vagina often. The clitoris was in a state of erection.

During this intermission they vainly endeavored to give her large doses of quinine.

With the next morning came a new attack, and she sprang from her bed, threw off her night dress, ran downstairs and jumped into the arms of a carpenter whom she urged to amorous assaults. She was now tied hand and foot and watched by four muscular maid servants. The priest endeavored a second time with his prayers and canticles to drive away the demons, but for fully seven hours the patient did not cease to make the most indecent proposals.

In addition to the symptoms of the preceding attack, a spasmodic contraction of the esophagus was noticed.

Before her confessor, her parents and her friends she recited the two first strophes of the "Ode to Priapus." This paroxysm lasted nine hours. Absolute prostration followed, the pulse became weak, hiccough and the risus sardonius came on and the patient expired.

An autopsy was not allowed. This was regrettable, for lesions of the genital organs and, very probably, lesions of the nervous centres would certainly have been found.

In 1871, Dr. Maresch* published a paper based on observations of nine cases.

In three cases the disease ended in death in from five to eight days.

In the others the acute nymphomaniacal exaltation lasted 10 to 14 days, but was followed by an insanity with a predominance of sexual ideas that lasted in the longest case three months, and disappeared only to make way for dementia.

The author after describing the disease sums up as follows: In the very acute cases the intervals of rest were extremely short; in the others the attacks of violent nymphomaniacal agitation were of shorter duration and came on at longer intervals.

The movements of the heart have always been accelerated and violent. They have reached as high as 140 to 150 a minute and the acceleration of the pulse rate has always been the most positive sign of the approaching fatal termination of the disease.

In most cases there was a well-marked edema of the scalp, which disappeared when there was a favorable issue.

The author adds some anatomopathological considerations, according to which he is inclined to consider this disease as localized in the posterior portion of the hemispheres; in addition he twice found a thrombosis and once a phlebitis of the sinus falciformis.

Without discussing these observations, I will call to your attention that they seem to show exactly the characteristics of attacks of the convulsive form of hysterical insanity combined with a general state of excitation, which may in certain cases go to acute delirium.

As you see, these cases show what a mistake it is to confound nymphomania with erotic insanity.

Nymphomania is an organic disease that furnishes at the autopsy either lesions of the genital organs or lesions of the nervous centres.

It differs absolutely from the genital excitations that we have just de-

scribed, and which, generally speaking, are not concomitant with well defined anatomical lesions. There are true cases of mental alienation, while nymphomania, such as we have just described it, is only one of the symptoms of an organic disease.

SATYRIASIS.

VI.

Satyriasis differs from nymphomania only in its greater severity and by the aggressive character of the patients, who are prone to attack persons of the opposite sex in order to satisfy their desires.

The ancients classed all forms of erotic insanity under the name of satyriasis.

Galen, Actius of Ameda, and Rufus of Ephesus, confounded satyriasis and priapism,

Paul, of Aegina, was the first to establish a distinction between the symptoms (priapism) and the disease (satyriasis), nevertheless his other ideas seem as confused as those of his predecessors.

Areteus is the first who seriously studied this disease. He was acquainted with its severity and its rapid progress. He had noticed that persons afflicted with it usually died in a week. "Nam plerumque in septima die hominem consumit."

Coelius Aurelianus* defines the disease, gives its etiology and its principal symptoms. He recognizes it as a form of insanity, "mentis alienatio." His observations are precise; he has evidently studied the disease.

Johannes Hartmann** observed that the issue of the disease is fatal, "per virium exolutionem tetanum et mortem."

Wolfgang Wedel*** the celebrated professor, of the University of Jena, and many others mention the gravity of the disease.

Satyriasis is a rare disease and especially so in our climate. It is much less frequent than nympho-

*Coelius Aurelianus, *De Morbis Acutis et Chronicis*, Amsterdam, 1700, p. 249.

**Johannes Hartmann, *Officina Sanitatis*, Noribergae, 1677, p. 640.

***Wolfgang Wedel, *Physiologica Medica*, Iena, 1590. Caput, xvi, p. 572 et seq.

*Maresch—*Psychiatriches Centralblatt*, 1871.

mania. The number of reported cases is very small.

Like nymphomania, satyriasis may result from a lesion of the nervous centres.

It has even been known to result directly from traumatism.

Chauffard, of Avignon, **** reports a curious case of that kind.

****Chauffard, Journal Universel des Sciences Medicales, December, 1888. ||

You see, gentlemen, that satyriasis and nymphomania are very dangerous diseases, which are associated with organic changes, differing absolutely, therefore, from erotic insanity.

It now remains for me to speak to you of perversions of the sexual instinct.

This will be the subject of our next lecture.

(To be continued.)





Editorial

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THE BELLEVUE HOSPITAL

"DRINK CURE."

During the past month the profession of the United States and abroad has been regaled with the news from New York, bearing on the Oppenheimer remedy for alcoholism, now on trial in Bellevue Hospital.

The "Medical News" claims for itself the credit of first bringing this matter before the profession; but, as a matter of fact, the Times and Register's announcement long antedated the former, and its ringing denunciation of the whole thing, the weak-kneed Medical Board included, to the support of which we notice the "News" of August 1 gives an editorial.

It, however, makes a rather lame defense and fails to answer the demand of the Journal of the American Medical Association, which in plain terms inquires "why this Medical Board has not resigned rather than submit to the humiliation and

contempt heaped upon it?" But the News says: "The infringements on the rights of the Medical Board were properly resented by that Board and an effort was made to induce the Commissioners to see the mistake they were making." It seems, however, that these Commissioners are incorrigible, or know the ground pretty well which they stand upon, for we have it from the highest authority that Dr. Oppenheimer has been authorized to continue his experimental work as long as he likes; and in this position we are in full accord. Those not informed on the subject would suppose that the medical colleges of which this Medical Board is practically composed had some vested rights in Bellevue Hospital, which is an erroneous impression, as they are permitted to attend there only as a matter of courtesy. This Medical Board seems to forget that not so long since

"Koch's lymph" (?) was experimented with repeatedly by this same august body, long before the German physician revealed its composition to the profession. Dr. Oppenheimer has the misfortune of not bringing his "remedy" from Paris or Berlin; being a domestic nostrum, it must be ridiculed, and he not being the son or second cousin of some attending member of the hospital staff, he must be kicked out.

But the Medical Board of Bellevue has, nevertheless, been commanded by the Commissioners to investigate the results of the treatment, which, of course, they are unable to do, although they did respond: "To the Honorable Board of Commissioners * * * *—In view of our long public service in your hospital, we feel justified in deprecating the trial in the hospital of any secret remedy or plan of treatment as opposed to the universally recognized traditions of our profession, and to the best interests of the sick poor under our care."

Liberty, oh, liberty, how many crimes are committed in thy name

Oh, no, gentlemen of the Medical Board, this sort of tactics will not answer. What are we to understand by your "long public service" while there are among you physicians who are not yet ten years out of a medical school, and others not a year attached to the service?

But they deprecate a plan of treatment of which they candidly confess they know nothing.

And they are seriously shocked lest the "traditions" of the profession be disregarded. Consistency again. We remember, however, within the period of a year, how remorselessly this rapacious, heartless Board secretly conspired to plunder and wreck the fortunes of their brother-practitioners and surreptitiously secured possession of their positions, in order that the colleges might dupe the public into believing that their members alone, their faculties, were capable or should be permitted to take an advanced position in their profession or qualify as consultants.

Our esteemed and aggressive contemporary, the "Medical and Surgical Bulletin," too, seems to have its

head turned in its "Talk with the Commissioners," and proceeds with its denunciation of public officials—against whom it can prove nothing—in such insulting and threatening language as will most certainly defeat the ends in view. The German Government purchased Koch's secret remedy and ordered a thorough trial of it in the imperial hospitals, without requesting any opinions of the Medical Boards. When the thing fizzled out, and was proven worthless, its composition was revealed. The New York Board of Health introduced and enforced the use of anti-toxin for many months before its real value was decided on by the medical profession, and to-day in Genoa, Dr. Maragliano has two large wards at his command in the Ospedale San Marco, the largest public hospital in the city. It will be remembered that this gentleman was the secretary of the late International Medical Congress in Rome, who is now testing a secret remedy for tuberculosis.

No! Bluff and bluster will not swerve the Charity Board, nor menaces move them from a course strictly in the line of justice and humanity.

Let none of our readers misunderstand our attitude in this matter, for there is no organ more ready, not only to "deprecate"—not in any namby-pamby fashion, quackery—but to denounce and condemn it in any form of its hydra-head may present; but our first duty is to the profession at large, and we intend to fearlessly expose imposters as well as crush quacks. It strikes us, however, that Bellevue Hospital's Medical Board should do a little "sweeping before its own doors" before it exhibits another spasm of virtuous indignation.

Let it strive to make restitution for some of its lately ill-gotten goods before it is forced to do so on such conditions as will forever strip it of its former dignity and self-respect; and let it prove that the ends and aims of its members are not equally or more mercenary than the "stock companies" which it affects to despise.

STOCK COMPANIES AND HOSPITALS.

The late innovation in Bellevue Hospital has produced quite a stir in the profession in New York.

The "Medical Times and Register" was the first medical journal in this country to make the announcement that the Commissioners of Charities, of New York, on the authority of the Mayor, had ordered a trial of a new remedy for alcoholism in Bellevue Hospital and in so doing had ignored the Medical Board, which Board, let it be remembered, by intrigues and treachery, displaced 20 of their professional brethren about one year ago and duped the old Board of Commissioners into believing that they were authorized to speak and act for the commissioners, their defense being that "because the plan in operation at Bellevue had been so successful it was deemed desirable to extend it to the other hospital," a statement wholly without foundation in fact, as no doubt the forthcoming investigation will prove.

The present Board of Commissioners, we learn, have decided to take the reins in their own hands and manage the hospitals under their charge according to their own ideas, rather than be instructed by advisers who have led them into inflicting a great wrong on the profession.

With reference to the "new remedy" now on trial in Bellevue Hospital, it has been alleged by the Medical News in a recent editorial that it is being governed by a "stock company" and manipulated by a corporation.

Well, the code of ethics, which is to-day practically a dead letter in New York, denies one the right of membership who owns a patent, but it constantly does not interfere with the right of medical men to incorporate, besides, let it not be lost sight of that every medical college in New York is a "stock company," strictly speaking, with nominal connections with chartered institutions, the peculiarities of which, having practically no interest in the advancement of physicians not connected with them.

This was clearly demonstrated in the "reorganization" scheme of a year ago, when their rapacity and selfishness became too transparent to escape condemnation.

This Bellevue Medical Board have all along played a shrewd game and given an impression to citizens that the members held their position in virtue of some hereditary right, and that some great calamity must follow their absence from the service.

But the fact is, as Judge Andrews of the Supreme Court, lately decided, the Charity Commissioners alone are responsible for the medical service of the public hospitals, which plainly means that medical college teachers are in them now only as a matter of courtesy and not by any prescriptive right, and that the commissioners are at liberty at any time to introduce any line of treatment they may decree expedient and proper safeguards, be it either eclectic, homoeopathic or otherwise. The Medical Board of Bellevue affects to look with disdain on the eclectic and homoeopathic practitioner, but the legislation of the State has conferred on them co-equal powers. It is about time that we opened our eyes to a little of past history in medicine. It should not be forgotten that vaccination when first introduced by Jenner met with the most violent opposition, and that when Simms, the pioneer in gynecology, came to New York the profession gave him a most hostile reception, and had it not been for a committee of public-spirited and independent women of New York the work of that gentleman would have been lost to the profession. Neither should we forget that Koch kept the composition of his tuberculin a profound secret until it was proven a failure. There is much to be said pro and con in connection with this subject of patients, although many of the most advanced and progressive practitioners believe that the fact of one being a physician should not prevent him the right to enjoy

the fruits of an invention of serious or extensive research.

From what we can learn the Charity Commissioners of New York are interested in a most humane and laudable work in the matter of moral and physical treatment for the unfortunate inebriate, rather than the late primitive, brutal course in vogue, which offered the poor wretch nothing but the misery and degradation of the cold, damp, dismal cell

and ten days in prison.

By all means let the profession give their united support to any scheme that may open the way to a more rational and curative course of treatment for the drunkard. Let this Board then be a truly "charitable" one and maintain an unflinching support to a line of treatment indorsed by Drs. Crothers, Quimby, W. S. Davis, of America; Norman Kerr and others in Europe.

ADVANCES IN HEPATIC SURGERY.

The modern advances in the progress and evolution in the surgery of the hepatic ducts constitute a new era in this direction.

In 1884 Langenbuch and in 1885 Parker for the first time opened the common duct for the displacement of biliary calculi. In 1890 Kummel really performed secumdern artera, the first cholecotomy. He was soon followed by Heussner, Thornton, Courvosier and Riedel. Terrier, at the sixteenth congress of French surgeons reported 13 cases of cholecotomy performed by himself, and last year his student, M. Jourdan, collected an aggregate of 72 cases performed by different surgeons.

Quenu, Michaux and Vautrin have given special attention to the anatomical consideration of the subject and in this country our surgeons have kept apace, if not in advance, of their European cousins, notably Bull, Fenger, Murphy, Elliott and several others.

Until indeed a very recent date in many of the worst cases of icterus beyond palliative medication we were able to accomplish practically nothing. Sweet oil was a favorite empirical remedy to dissolve the bile-stones. But it has been recently proven that it is quite inert, except as a laxative and that the globular masses ejected after its administration are not biliary calculi, but saponified and discolored particles of the congealed oil.

Operative surgery has opened the

way to the only possible way of relief in many types of biliary obstruction, by means, although often attended with danger to life and invariably difficult, except by an experienced and skilled hand.

One of the most formidable difficulties lies in the way of diagnosis; to discriminate between obstructions produced by concretions in the ducts and those caused by morbid growths. For the former much may be accomplished by medicines and operations, and for the latter practically nothing.

The technique of hepatic surgery has been wonderfully improved during the past ten years. One of the most important advances in this direction of late years has been the use of the Murphy button, in quickly effecting a cholecysteterostomy. There are many instances, however, as in contracted or diseased gall-bladder, wherein it cannot be applied, besides, even when successful, the constant infection of the gall-bladder by the intestinal contents, is a serious objection.

Vautrin has lately demonstrated by a considerable number of successful cases that the common duct is everywhere accessible to exploration, from its origin down to Vatter's ampulla, at the orifice of the intestine, and Elliott, of Boston, has shown by quite a number of operations that cholecystotomy, with removal of the calculus and rupture of the duct is practicable in any part

of its course. This renders practically obsolete the former palliative operation of cholecystotomy, and definitely establishes the position of the proper line of surgery for that once almost hopeless condition of calculus obstruction of the common bile duct.

Conceding, however, the brilliant advances of modern surgery on the viscera and tubular structures within the abdomen, the question arises, must we then concede that constitutional, systematic medication is inert and impotent in all these grave cases?

This is the serious problem we have to face and resolutely grapple with. Apriori, one would answer, if those disturbances which gave rise to these conditions are diabetic and provoked by disturbances with physiological processes; then surely the way to reach them would be through the blood, without shock or violence to the system, rather than by a breach through the abdominal walls, a procedure which must always be attended with a large mortality in consequence of the deteriorated

general health of the patient and the inherent danger of the procedure. Surgery in these cases should indeed be regarded as an opprobrium to the healing art, and as not a substitution of mechanical and violent means for what should and no doubt can be often remedied by internal and surface therapeutics. Wash out the clogged passages, dilute the secretions and administer solvents; clear the colon from below, make up the deficiency of bile by ox gall, and employ methodically massage and the deep Swedish movement.

That this is no visionary view is duly proven in the hands of scientific, conservative practitioners, and by the late utterances of that prince of abdominal operator, Dr. Nicholas Senn, who declared at the late meeting of the American Medical Association that biliary surgery was highly dangerous and that the German surgeons themselves, when afflicted with biliary calculi, instead of submitting to the scalpel, rushed off to Carlsbad Springs for relief, and generally returned home cured.

<p>COCAINE C.P. ANHYDROUS CRYSTALS. STANDARD OF PURITY THE WORLD OVER.</p>		<p>MURIATE BOEHRINGER-B.&S. DISPENSED BY ALL DRUGGISTS</p>
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CARDIAC NEUROSIS AND ITS ELECTRICAL TREATMENT.

By W. F. Robinson, M. D., Albany, N. Y. From advance proof sheets of transactions of Electro Therapeutic Association.

(Continued from last number.)

SEVERE TREATMENT.

The nervous apparatus of the heart consists of four parts. The motor ganglia, which are imbedded in the substance of the heart itself and which may be called the prime movers of the heart; certain fibres of the pneumogastric and spinal accessory nerves, whose action is to slow the heart; certain fibres which run down the spinal cord, passing out with the spinal nerves and thus to the heart. Their action is to accelerate the heart beat. Lastly the nervous centres in the medulla, where the impulses of the heart originate. In cardiac neurosis some of these parts are at fault and the indication is therefore to bring them to their proper condition and function.

At this point the writer must frankly confess his ignorance, for he is unable to state positively just which part of parts of this delicate mechanism is out of order. In this dilemma he has adopted the following expedient, which perhaps should be properly called a makeshift.

A form of treatment has been adopted with the object of toning up this whole system and thus inevitably reaching the parts which need it, whichever they may be.

The way to tone up a nervous tract which has become depressed in its function is to bring it as directly as possible into the path of the electric current.

If, therefore, an electrode were

placed over the medulla and another at the point where the apex beat of the heart is felt, it would seem to fulfill all the conditions. This is not true, however, for it violates one of the most important canons of electro-therapeutics, that which tells us to avoid causing irritation. The brain being an extremely sensitive organ cannot bear but a small dose of electricity, much smaller than is necessary to apply to the other parts of this system. The electrode over the medulla would bring the direct current so close to the brain that there would be great risk of causing irritation to that sensitive organ, especially in susceptible subjects.

The positive pole is therefore placed not over the medulla, but low down on the neck, where its junction with the back gives good surface for its application. This method has proved in general very satisfactory, but this matter will be referred to later on in connection with others.

As to the form and kind of electrode, the writer prefers those made of copper wire gauze for many reasons. They are flexible and adapt themselves readily to the inequalities of any surface. They should be oval in form and about the size of the palm of the hand. The wire should be protected by a thin layer of absorbent cotton, and the whole covered with a layer of flannel.

The cotton is excellent to hold water and protect the skin from too

close proximity to the metal. The flannel simply serves to keep it in place.

The positive pole should be applied to the back of the neck just where it joins the shoulders. Care should be taken that it fits well over the spinous processes, which are quite prominent in this region, and makes good firm contact all around. If the electrode presses unduly upon these processes it may cause irritation at their apices.

The negative pole should be applied to the cardiac region.

When the writer first applied these treatments he was very careful to place the negative electrode directly over the apex of the heart. He has since learned, however, that it does just as well to apply it in the median line over the sternum. The probabilities are that the current traverses the nervous tissues just as well in the latter case as in the former, and perhaps a little better. As to the dose applied, it is extremely difficult to lay down general rules and it is just here that individual skill and experience come in. There is undoubtedly a certain dose that will produce the best effect, but it varies in each case and it is therefore no small difficulty to determine just what it is.

In general it may be said that the proper dose for these cases is a small one, and that they do not as a rule bear much of an increase.

The following case will serve as an illustration of what has just been said:

A married woman, 35 years old, consulted the writer for the following symptoms: She was terribly nervous and had enough in the relations of her married life to make her so. Her heart gave her constant trouble. She would have to sit down two or three times in going upstairs. She would have a feeling of suffocation as if she must get into the air. Heart would beat very rapidly and then stop. It would often disturb her so that she could not sleep, but must sit up all night.

This patient was very sensitive to electricity and could only bear the smallest doses. The first treatment

was a current of two mille-amperes, allowed to pass for five minutes, the electrode being applied to the neck and cardiac region in the manner described above.

The night after this first treatment she slept right through, a thing she had not done before in a long time. She was told to come every other day and did so, with occasional exceptions. After eight treatments she was so much better that she discontinued her visits. An attempt was twice made to augment the effect of the treatment by increasing the dose, but both resulted in failure. The patient was made worse each time.

This was an extremely small dose, almost a minimum, and yet it was undoubtedly the proper one for this case.

The reason for this was that the patient was in a very nervous and excitable condition, due to worry of mind and the nerves of the heart, as well as the whole nervous system, were highly sensitive to any external stimulus.

The same fact is often shown in the administration of drugs.

A patient whose nerves are unstrung from any cause will exhibit an astonishing sensitiveness to ordinary doses, so that the greatest care is necessary in their administration.

A second case may be cited to still further illustrate the application of this method. It was that of a married lady about 30 years old, in whom the family physician suspected the existence of fatty heart. She had a great deal of pain and distress in the precordial region and a very irregular pulse. It would beat sometimes fast and sometimes slow, and there was also a difference to be noted in the force of the beat at different times.

She was inclined to stoutness, but had an excellent color and did not look in any respect like an invalid. She was not troubled with palpitation except when excited or angry. She would lose her breath on the least exertion, however, and it was very difficult for her to go upstairs.

This patient received the regular

cardiac treatment, the same as the former. The dose was rapidly increased to 10 mille-amperes, given for six minutes. She received treatment three times a week and steadily improved under it, although not as fast as the other patient. The treatment was continued for about two months and a half, with occasional intermission. At the end of this time the pulse was fairly regular, the cardiac pain was so slight as hardly to trouble her at all, and she could go upstairs as well as any stout person who was not in the habit of taking much exercise.

This patient differed from the first one in that she was very happy in her family relations and had nothing to worry about. She was also of an extremely phlegmatic temperament and was calm to the point of indifference. It is not strange, therefore, that this patient could bear a far larger dose than the former.

As to the question of diagnosis, it may be claimed that the writer is entirely wrong in classing this case under the head of cardiac neurosis,

as it was in all probability one of fatty heart. To this he would reply that if this really was a case of fatty heart, the fact of its being so strikingly helped by electricity shows a power in that agent far beyond what has yet been claimed for it. In view of the difficulty and uncertainty of diagnosing fatty heart it seems fair to mention this case in this connection, since the treatment prescribed for functional troubles acted so well upon it.

These two cases show what electricity can do for the heart, and many others might be cited in which similar good results were obtained.

It must not be supposed, however, that this is the only way in which the nerves of the heart can be reached.

After trying various methods the writer believes that the one described is the best, but a wider experience may demonstrate that some other is better.

The only way that this question can ever be settled is by careful and continued observation of cases and comparison of the results obtained from the application of different methods of treatment.

THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The sixth annual meeting of the American Electro-Therapeutic Association will be held on Tuesday and Wednesday, September 29 and 30, and Thursday, October 1, 1896, in Allston Hall, The Studio Building, on Clarendon street near James Avenue, Boston, Mass.

The Brunswick Hotel, corner Boylston and Clarendon streets, will be the headquarters of the Association during the meeting. Terms, reduced to \$4 per day, for Fellows and their friends. The Copley Square Hotel, corner Exeter street and Huntingdon avenue, terms reduced to \$3 per day, is also located in close proximity. For rooms, etc., apply either to the proprietors or to Dr. W. H. White, No. 222 Marlborough

street, Boston, Mass., who, as the vice chairman of the committee of arrangements, will reserve rooms.

Professor A. E. Dolbear, Tufts College, Mass., is chairman of the committee of arrangements.

Dr. W. H. White, 222 Marlborough street, Boston, Mass., is the vice chairman of the committee of arrangements.

Dr. Frederick H. Morse, Melrose, Mass., is the chairman of the committee of exhibition.

The next annual meeting promises to be a greater success than any former one. Great interest is shown in all quarters. A large attendance is promised. Many candidates of national reputation are proposed for membership, so that the amendment

to increase the limit of members becomes a necessity. The best talent has already announced papers, a larger number than ever before, at this early date; material almost sufficient to make a programme for the session of unusual interest. There will be two discussions of importance in electro-therapeutics, interesting reports of all standing committees, several scientific lectures on the first evening, with demonstrations and stereoscopic views (including the Roentgen X Rays and electric principles in the treatment of diseases), given by eminent talent.

The committee of arrangements has surprises in store for the social element in receptions and excursions.

The exhibition promises to be a good feature, and of more than usual interest.

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Committee of Exhibition—Dr. Frederick H. Morse, chairman, Melrose, Mass.





Book Reviews.

Implantation of a Glass Ball in the Orbit after Enucleation of an Eye. Reprint from "The Medical Bulletin," July, 1896.

L. Webster Fox, M. D., of the Medico-Chirurgical College, Philadelphia, has devised a new operation for aiding the better adjustment of an artificial eye. He calls it "Implantation of a Glass Ball for Support of an Artificial Eye."

The operation is as follows: An incision is made through the conjunctiva and tissues of the orbit in the horizontal direction, a shade less than the diameter of the glass ball to be inserted; for instance, if the glass ball is one centimetre in diameter the cut would be two millimetres less. The upper lip of the conjunctiva is raised, and with a sharp-pointed, curved scissors the conjunctiva

and such connective tissue which lies close to it is dissected off in all directions around the incision, making a pouch into which the glass ball will fit. On account of the vascularity of the parts considerable bleeding follows this dissection, but it is easily controlled by pressure; after the bleeding stops the glass ball is inserted into the cul-de-sac with the injector. The edges of the conjunctiva are brought together by five or six stitches, and the after-dressing is the same as that followed in the evisceration cases.

This operation will remove much of the objectionable features of wearing an artificial eye. It has been proven in Mules' operation that the sinister stare, loss of movement, as well as the accumulation of mucous, are dispensed with. These same objections are overcome by Dr. Fox's method.



Current Medical Literature.

TREATMENT OF VENEREAL LESIONS.

The value of iodine as a disinfectant was recognized long before the inauguration of the antiseptic era of the wound treatment. But it was not until this period that efforts were made to synthetically prepare substances, which, when brought in contact with a wound surface would yield up their iodine in small amounts so as to exert a constant germicidal action. Iodoform was the first iodine derivative brought before the profession, and in many respects it has held its own. Of late, however, attention has been quite frequently drawn to the fact that this substance sometimes gives rise to irritant and even toxic effects. Aside from this, its telltale odor is objected to by many patients, and is equally objectionable to many physicians. The desirability of securing an iodine derivative devoid of these unpleasant properties, yet as efficient as iodoform, is therefore fully apparent. Europhen has been found by many competent observers to possess all the advantages of its malodorous rival, while completely free from its disadvantages. In the treatment of venereal diseases europhen has proved to be of especial value. That extremely common affection, chancroid, rapidly yields to its antiseptic and cicatrizing properties. If dusted on the sore after cleansing with a mild carbolic solution, healing progresses with great rapidity, and it will rarely be necessary to resort to the use of caustics. It has also been claimed that under its use buboes are seldom developed. If they form, however, and undergo suppuration, the application of europhen to the cavity, after evacuation of pus and curettage (when required) will be found to induce

rapid healing. For the treatment of other venereal lesions, as ulcerating chancres, condylomata secondary and tertiary syphilis, europhen has also shown itself to be a very efficient and agreeable remedy, which is perfectly unirritating and free from poisonous qualities.

TREATMENT OF ALOPECIA AREATA IN CHILDREN.

Feulard employs the following at the Hospital des Enfants Malades: The hair is cut as short as possible with scissors, and the following ointment applied:

Vaseline,
Lard of each 225 grains
Precipitated sulphur 45 grains
Salicylic acid 15 grains

Next morning the head is shampooed with salicylated soap and then friction is applied with a soft brush soaked in this mixture:

Alcohol,
Tincture of Rosemary.... of each 3.38 oz.
Corrosive sublimate ½ grain

Once a week the patches may be painted with a brush soaked in

Essence of wintergreen,
Ether equal parts

—Rev. Intern. de Med. et de Chirurg.
Pratiques, September, 1894.

ORAL OVOIDS.

Dr. Pollak adds 10 per cent. of carbolic acid to the gelatine amygdalae aurium, suggested by Professor Gruber; he used them chiefly in circumscribed external otitis and found they very rapidly relieved the pain and, in about 70 per cent. of the cases, aborted the morbid process. He also found them useful in the early stages of acute median otitis.

—Journal of Larynx, June, 1896.

FISH POISONING.

Brosch (Wien. klin. Woch., March 26, 1896) reports the first case of poisoning by oysters which has proved fatal (in 22 hours). Symptoms: Vomiting, giddiness, paralysis of certain muscles (paralysis of deglutition, dilatation of one pupil, ptosis, obliteration of naso-labial furrow, paralysis of accommodation, larynx, bladder, with general weakness). Consciousness was preserved till death, which is due to paralysis of respiratory muscles. Post-mortem: Brain and pia mater edematous; small punctiform hemorrhages in cerebellum and lower dorsal and upper lumbar region of cord; numerous petechiae on pericardium and pleura; mesenteric glands, intestinal follicles and Peyer's patches not enlarged; spleen enlarged; fatty degeneration of hepatic cells and parenchymatous degeneration of cardiac muscle and renal cells. No micro-organisms were found in the spleen or spinal cord, and cultures were sterile. On analysis of contents of stomach, small intestine and bladder no mineral or vegetable poison was found, but ptomaine-like bodies were present which had no special characteristics. Thirteen similar cases of fish poisoning have been published. The symptoms are like those of one form of meat poisoning, but the course is much more rapid. The post-mortem descriptions of all agree except as to changes in the lymphatic system and the presence of hemorrhages. The latter simply depend on the mode of death, and are present if it is from asphyxia, absent if from collapse. The symptoms are also characteristic: (1) Progressive development of isolated muscular paralysis, the only difference in the cases being the number of groups attacked and the intensity of paralysis. Paralysis of deglutition and general weakness almost always appear first, then disturbances of vision, the other paralyses coming on in no constant order. (2) Giddiness is always present, and gives the appearance of drunkenness, but consciousness is preserved till death in all but very rapid cases. (3) Temperature normal or very slightly raised. (4) Pain frequently absent. (5) Death is due

to respiratory paralysis, if it does not occur early from collapse. Excluding some cases of poisoning by mussels, where in the slightest form there is urticaria, and in the most severe form muscular cramps, loss of consciousness, and death, poisoning by meat or fish occurs as two distinct groups: (1) True gastro-enteritis with high fever and colic, and generally ending in recovery (due to intestinal bacterial infection); (2) the form described above. Besides the obvious differences, diarrhea is present in the first, while in the second there is constipation, caused by intestinal paralysis. This division is of great importance with regard to prognosis and treatment. In the gastro-enteric form purgatives and intestinal disinfectants must be given; in the severe toxic cases they are useless on account of the paralysis. Hence (1) use stomach pump and irrigate the intestine as high up as possible; (2) artificial feeding by tube; (3) frequent catheterisation; (4) artificial respiration, which must be continued for several hours, until the poison may have been excreted by kidneys. (Compare curare poisoning). This, however, is not always successful, one case having succumbed after nine hours of artificial respiration, and if recovery ensues the paralyses always persist for some time, and may be permanent. Pathology: The above suggests that the paralysis is caused by a grave anatomical lesion, which, however, cannot be produced by the hemorrhages, as these may be absent. Perhaps the edema and cellular exudation from the vessels into the substance of meninges, brain and spinal cord may explain it. The poisoning itself is not due to bacterial infection, but to an intoxication from alkaloid-like substances present in the animal, many of which have been isolated.

ENTERIC FEVER.

A febrile temperature with any marked morning remissions for 14 days, and accompanied by no physical signs of inflammation of any organ or tissue to account for it, is most probably due to enteric fever.

And so long as any doubt exists, insist on your patient remaining in bed and being placed on a rigidly febrile dietary. I am pretty sure many lives are sacrificed in cases of typhoid, which, mild at first, become virulent subsequently, owing to their non-recognition and therefore improper feeding.

—London Medical Times.

SEA BATHING.

The great benefits derived from the inhalation of fresh sea air and from sea bathing cannot be too highly appreciated; but, as in the case of all other remedial agents, their use has its bounds and its qualifications. People accustomed to a non-invigorating inland atmosphere cannot with impunity expose themselves to the often keen air of the seaside. As a rule they require warmer clothing than at home, and when want of strength reduces the power of taking exercise the sense of drinking-in health with the air does not justify sitting for long in exposed positions and without shelter. In respect of bathing we may speak more strongly.

* * * Even for robust persons of

good swimming power a prolonged immersion is productive of exhaustion. Doubtless strong people, and perhaps even weakly ones, can stay in the stimulating salt water longer than they can in fresh without feeling the bad effects of the lowering of the temperature of the body; and it must be admitted—nay, urged—that every individual body has its own rule. In use, even for healthy people coming from the enervating air of large cities, the first baths should certainly be of short duration. They should include, if possible, a plunge into water sufficient to cover the shoulders, and, if possible, a short swim. The water should be quitted in a few minutes, before depression has followed stimulation. The condition of the bather after the resumption of his clothes will soon afford a test of the exposure which he may undergo with advantage. This will consist, on the one hand, in a sense of warmth, refreshment and readiness for muscular activity; on the other hand, subsequent feeling of nausea, of chilliness, of headache or of palpitation will show that the just measure has been exceeded.

Dr. W. M. Ord: The Climate and Baths of Great Britain.



Current Surgical literature.

T. H. MANLEY, M. D., New York, Editor.

TREATMENT OF FRACTURES BY MASSAGE.

M. Fevrier presented records of 29 cases of fracture treated according to the precepts of L. Championniere.

Four fractures of clavicle, two with considerable displacement; all well united from 20 to 30 days.

One fracture of the diaphysis of humerus. Cure.

Three fractures of lower end of humerus, mobilized and extended. Massage early; union in 30 days.

Four fractures of radius (Colles'). After 15 days active movements commenced.

One fracture of middle of ulna. Cure in 21 days.

Three fractures of the leg, one in upper one-third of shaft, no displacement; immediate massage; cure in 22 days. One in middle third, with considerable blood extravasate; early massage; walked on thirty-second day. One with a V-shaped fragment communicated; opposed for 11 days; cured in 30 days.

Three fractures at tibia-tarsal joint. The duration of treatment, 11 days.

Eight fractures of the maleoli, double, with hamethrosis. Duration of treatment, about 22 days.

Two fractures of the metatarsal bones, without displacement. One walked in 13 days and one on 15th day.

Th. Weisse had treated five fractures by this plan, and was not able to felicitate himself on the results.

M. Heydenreich had lately recognized that massage occupied an important place in fracture treatment, but it must be utilized with judgment and discrimination. It would be well to employ it with caution when there may be much displacement, but in fractures near the

articular lines it may be of great value, through its effects in hastening the resorption of the callus and stimulating the circulation. By frequently removing the dressing he was enabled to bathe the limb and correct deviations.

M. Gross believed that massage is often useful in fracture of the smaller bones, and in those of the larger, near the joints.

Its action in hastening consolidation of the long bones, after the fracture, was only problematical. Where primary union was complete or was delayed, removal of all splinting and daily massage hastened repair and obviated ankylosis.

M. Vantrien had three severe fractures of the upper third of humerus treated by Championniere's method, with two failures. In his opinion it was a great mistake to make a wide application of this plan of treatment, for it under no circumstances should be accepted as a substitute for other and longer tested plans. We fully agreed, with others, as to the utility of massage after the provisional callus is proved, but before this time, when all the tissues are torn, crushed and influenced, early manipulation is baneful and will rather interfere with than hasten final cure.

—Soc. de Chirurg. de Nancy, 27 Mai, '96, *Review de Med.*

INJECTIONS OF ARTIFICIAL SERUM—SALT WATER.

At a late meeting of the French Academy of Medicine M. Pozzi made a report on M. Delbet's work relative to the treatment of post-operative treatment of septicemia by injections of artificial serum into the veins. He called attention to the fact that this plan of treatment was

now generally practiced in all the Parisian hospitals. He preferred to give the injections subcutaneously, seven parts of sea salt to 1000 of water. In the discussion which followed Mr. Recius stated that a case of hydrophobia lately came under his care which had been unsuccessfully treated in the Pasteur Institute for 15 days. M. Delbert injected 1300 grammes—about three pints. Its immediate effect was to produce a calm, but the boy died a few hours later.

M. Championniere had obtained good results with it for shock and anemia, but in septicemia it had no effect.

Pinard had similar experiences, and Doyers and Logie, who in 1889 declared, after several experiments, that the serum had no effect in septicemia.

M. Pean took exception to this and cited the remarkable results in the hands of M. Berlin, who claimed that the pathological germs were washed out of the blood by the salt solution. M. Championniere declared that Berlin's deductions were not reliable, as he was an enthusiast who recommended it as a panacea for everything. He did not doubt that this therapeutic resource had a place, but was by no means innocent in its effects, and just now was being greatly abused.

MM. Pean and Dumontpallier would be pleased if some definite rule for the use of the serum could be contrived. The latter doubted the utility of the artificial injections, even in hemorrhage, and would rather trust in ether injections; he would certainly not allow a surgeon to inject them into him.

M. Pincard alleged that he had lately injected the serum artificially in 17 cases of females, who in former times must have all perished.

M. Tarnier had seen the method succeed well in hemorrhage. He had never used it in septicemia, which of late years has become rare; however, it was not always mortal by any means, and when one recovered after the serum it was a question of "post hoc ergo propter hoc."

—Soc. Francaise, 30 Juni, '96.

A NEW COMPLICATION IN HYPO-GASTRIC PUNCTURE OF THE BLADDER.

M. Gailhefer, of Toulouse, reports the following interesting case, which illustrates some of the dangers attending vesical puncture by the suprapubic route:

On May 26 a patient entered the Hotel Dieu, of Toulouse, in the service of Professor Juennel, with a letter from his family physician, of which the following is a summary: "Retention of urine caused by a voluminous prostatic tumor, filling pelvis; patient 70 years old; catheterism impossible; hypogastric puncture making a palliative procedure."

At the first trial, M. Juennel passed a sound with the greatest ease. It was evident that the prostate was injured and was the seat of infection. On following day patient was in a serious comatose condition, and three days later he died. During the last days of his life he fell four times out of the bed.

On autopsy it was seen that he had an enormous subperitoneal hematoma, occupying the space of Retzius, advancing up as far as the umbilicus and latterly as far as the kidneys. The anterior wall of the bladder was deeply ecchymotic. There was no hemorrhage into the peritoneal cavity. The prostate was about the volume of an egg. There were two deep, penetrating wounds in the lateral walls of the prostatic urethra. The hematoma had no direct connection with these. No blood in the bladder. Right kidney hypertrophied. One section, an encysted tumor, the volume of an egg, was found. Ureters permable and not dilated. The evidence of autopsy pointed to pyelonephritis as the immediate cause of death, and not the extravasated blood. Our author goes on to say, that in all these cases one should first assiduously try to catheterize, and, this failing, perform a cystotomy, using cocaine only as an analgesic, draining with a tube or a few strands of catgut. In all cases the peritoneal coat of bladder should be sutured to the integument. This temporizing and using the trocar might do in another age.

The practitioner should cut freely down and draw off the urine according to the rules governing modern surgery.

—Gaz. Heb., 3 Juillet, '96.

Note by Translator.—We cannot forbear right here to subscribe a few words apropos to these notes and would summarize them as follows:

First—In prostatic obstruction catheterize with caution, remembering the distorted curve of the urethra in these cases.

Second—If resistance is persistent there is seldom any possible danger to be feared, though a little delay. The urethra is irritable and the seat of extreme muscular spasm; when its passage it may be coaxed, but not forced. Allay the patient's fears, give a hypodermic of morphine, a free enema of very warm soap suds, to empty the colon; deplete the pelvic vessels and soothe the irritability. In catheterizing use just enough force not to start hemorrhage. A flexible catheter is the best, though sometimes the stylet is necessary to secure the proper curves. If this plan is followed patiently very few cases will resist canalization.

Third—If the moderate catheterism fail and the degree of distention is very great we should operate through the space of Retzius, shaving and thoroughly cleansing the surface before passing in a thoroughly aseptic needle.

Fourth—Aspirate away about two-thirds of the urine only. Usually after a few hours repose the bladder will empty itself or a catheter may be readily passed.

Resection of the prostate by any method is always an operation attended with a large mortality. The safest and most comfortable mode of relief for this class is by systematic catheterization. Palliative treatment must be carried out by a gentle hand without regard to the expenditure of time.

The urethra is an organ which may be successfully treated for stenosis of its lumen, either spasmodic or organic, whether acute or chronic, provided only one possesses the requisite skill, has an ample supply

of bogies and sounds, and is ready to expend the time. This applies to strictures as well as to prostatic obstruction or contraction of the ring muscle in the neck.

T. H. M.

LEGAL LIABILITY OF A MEDICAL AND SURGICAL INSTITUTE FOR THE FALSE REPRESENTATIONS OF ITS PRESIDENT AND PHYSICIAN IN CHARGE AS TO THE CURE OF A PATIENT.

The representations made to a patient by the president and physician and surgeon in charge of a medical and surgical institute as to his ability to cure him and on the strength of which representations that at the institute they could and would cure him, he was induced to pay the sum of \$500 for such medical and surgical treatment for injuries from which he was suffering, when L., the president, did know, or should have known, from his experience as a physician and surgeon, that the injuries of H., the patient, were incurable, may be made the basis of an action for deceit.

In this case there was a verdict for the plaintiff for \$500 and interest and the Supreme Court dismissed the appeal of the defendants and affirmed the order of the lower Court denying them a new trial.

The Supreme Court, in spite of the zeal and apparent sincerity with which they were urged by counsel for the defendants, passed over their 37 assignments of error, relating principally to the admission of evidence, as not requiring special reference, and based its opinion upon what was the real question in the case, the sufficiency of the evidence to support the verdict, and this, in turn, depending mainly on an inquiry as to whether the statements and representations alleged to have been made and said to have been relied on, were actionable.

The facts of the case, as they appeared in evidence at the trial, were that H., the plaintiff, an illiterate man, badly injured in an accident

and physically a wreck, consulted with the physician and surgeon in charge of a medical and surgical institute or hospital as to his condition and the probability of a recovery. After an examination by the surgeon he was positively assured, if he told the truth as to what was said (and the jury found that he did), that he could be cured, and by treatment at that institute could and would be made sound and well.

In behalf of the defendants it was contended that, at most, these statements were but expressions of opinion as to matters contingent and uncertain in their very nature, not susceptible of certain determination of actual ascertainment, and that therefore no action as for deceit could be maintained upon them. The Supreme Court in enunciating the rule of law applicable in such case said, "To sustain such an action, it must be shown that a false representation of a material fact has been made, in ignorance relied upon, and that damage has ensued. The representation must be fraudulently made, an intention to deceive being a necessary element or ingredient. But positive proof that a party knew his representation to be untrue is not essential. The intention may be proved by showing that, having no knowledge of the truth or falsity of his statements, he did not believe them to be true, of his own knowledge. When the knowingly false assertion is as to the belief of a party or is as to his knowledge of the fact he assumes to announce, intent to deceive is the inevitable inference. If this defendant, L., made statements and representations to the

plaintiff that his injuries were curable and that with treatment he could become a well and sound man, having no knowledge of the truth or falsity of his statements, and not believing them to be true, or if he made such statements, having no knowledge of their truth or falsity, yet representing that they were true, the intent to deceive is as well established as if positive knowledge of their untruthfulness had been proven. Generally speaking, the representations must be as to a material fact, susceptible of knowledge; and if they appear to be mere matters of opinion or conjecture, they are not actionable. There are many cases, however, in which even a false assertion of an opinion will amount to a fraud, the reason being that under the circumstances the other party has a right to rely upon what is stated or represented. Thus, the liability may arise where one has or assumes to have knowledge upon a subject of which the other is ignorant, and knowingly makes false statements, on which the other relies. Where parties possess special learning or knowledge on the subject with respect to which their opinions are given, such opinions are capable of approximating to the truth. And for a false statement of them, when deception is designed and injury has followed from a reliance on the opinions, an action will lie.

—From Int. Med. Magazine, April, '96.

We take much pleasure in indorsing the judgment in above case, for it is about time that some such sort of judicial admonition were administered to those who pilfer fees under above circumstances.—Editor.



Current Literature in Obstetrics and Gynecology.

E. D. KINNEY, M. D., Boston, Editor.

OVARIAN CYSTS AND SOFT UTERINE FIBROIDS.

Rendu (Lyon Medical, June 14, 1896) shows that a soft myoma often seems to fluctuate when it does not contain one single cystic cavity, and that whilst its symptoms and its feeling on palpation may lead to a right diagnosis, its appearance when the abdomen is opened may cause the operator to think for a time that it is ovarian. The use of the trocar settles the point that it is solid and not cystic, and on extraction its relations prove that it is uterine and not ovarian. Rendu's case was not clear from the first. The patient was single and 40 years old. Four years before operation she suffered from acute peritonitis. Menorrhagia had existed for five years. This symptom, however, may be due to other diseases besides fibroid, which itself may exist coincidentally with the development of an ovarian cyst. In Rendu's case the tumor filled the abdomen and seemed to fluctuate; there was a prominent secondary lobe on the left side, which may be observed in ovarian as well as in uterine tumors. On vaginal exploration the cervix appeared continuous with the tumor, and fibroid was diagnosed. At the operation fluctuation seemed distinct when the surface of the tumor was exposed. The trocar brought nothing away. The tumor proved to be a very vascular fibromyoma of the uterus, weighing 22 pounds. Twenty-two hours after operation, when all the blood had drained away, the sensation of fluctuation no longer existed.

ANTIPYRIN IN LABOR.

Savitzky (Vratch, No. 22, 1896), as the result of 17 years' experience, recommends antipyrin enemata as an obstetrical anesthetic. He administers 1 gramme every two to six hours,

occasionally combining the drug with opium (from 15 to 25 drops of Russian tinctura opii simplex, which contains 1 part of opium to every 10 parts). The pains are always relieved in 15 or 20 minutes after the first dose. Frequently the patient soon falls asleep, which is especially beneficial in cases of spasmodic uterine pains and tetanic contraction of the os; hemorrhage also diminishes. No untoward accessory effects were ever observed by the author.

MENORRHAGIA IN VIRGINS.

Laroyenne (Lyon Med., June 28, 1896) distinguishes the majority of cases of profuse menstruation in young girls, which require no local treatment, from a minority in which the use of the curette is advisable. If after long attention to hygiene and a course of suitable tonics menorrhagia persists, interrupted by occasional amenorrhea, granular or fungous endometritis probably exists. This disease is yet more safely diagnosed when the patient has been perfectly healthy and quite free from anemia before profuse menorrhagia appeared, and equally free from evidence of diseased appendages after the local symptoms become marked. When the excessive menstruation causes debility it is right to dilate and use the curette. A single application (immediately after the scraping) of cotton-wool soaked in equal parts of water and chloride of zinc is sufficient. Repeated cauterizations may easily cause atresia.

SUFFICIENCY OF MILK AFTER BIRTH.

Buchmann (Centralbl. f. Gynak, No. 25, 1896) observed 126 lying-in women in the obstetrical wards of

the Halle clinic from February to May, 1895 inclusive. He wished to ascertain the proportion of cases where the mother was able to suckle her child. Out of the 126 cases, 83 (or 65.9 per cent.) had sufficient milk when discharged between the tenth

and twelfth day. The percentages recently reported from Bale and Stuttgart were much lower. More statistics of this kind are called for, as they throw much light on the health and strength of women in different regions.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

Preliminary press notice of the ninth annual meeting, at Richmond, Va.

The ninth annual meeting of the American Association of Obstetricians and Gynecologists will be held at the Hotel Jefferson, Richmond, Va., Tuesday, Wednesday and Thursday, September 22, 23 and 24, 1896.

The proprietors of the Jefferson offer special rates to the Fellows of the association, their families and guests, as well as to any physicians who come to attend the meeting. It is confidently expected that the railways will offer transportation at a uniform rate of fare and a third on the certificate plan to all in attendance. Let all obtain certificates from their local ticket agents or from the nearest point where certificates are granted.

PAPERS PROMISED.

Note.—No attempt is made to arrange papers in the order in which they are to be read. That will be done in the permanent programme.

No. 1. Principles and Progress in Gynecology. President's address. Joseph Price, Philadelphia.

2. Vaginal Hysterectomy by the Clamp Method. Sherwood Dunn, Los Angeles.

3. Further Experience with Appendicitis. A. Vander Veer, Albany.

4. Relation of Malignant Disease of the Adnexa to Primary Invasion of the Uterus. A. P. Clarke, Cambridge.

5. Treatment of Puerperal Septicemia. H. W. Longyear, Detroit.

6. Treatment of Posterior Presentation of the Vertex. E. P. Bernardy, Philadelphia.

7. Relation of Local Visceral Disorders to the Delusions and Hallucina-

tions of the Insane. W. P. Manton, Detroit.

8. Differential Diagnosis of Hemorrhage, Shock and Sepsis. Eugene Boise, Grand Rapids.

9. Movable Kidney; Local and Remote Results. A. H. Cordier, Kansas City.

10. Pathology and Indications for Active Surgical Treatment in Contusions of the Abdomen. W. G. Mac-

11. Some Causes of Insanity in Women. George H. Rohe, Sykesville.

12. Subject to be announced. John Milton Duff, Pittsburg.

13. Shall Hysterectomy be Performed in Inflammatory Diseases of the Appendages? L. H. Dunning, Indianapolis.

14. Subject to be announced. Rufus B. Hall, Cincinnati.

15. Subject to be announced. George Ben Johnston, Richmond.

16. Dynamis Ileus, with Report of Cases. J. W. Long, Richmond.

17. Faradic Treatment of Uterine Inertia and Subinvolution. Charles Stover, Amsterdam.

18. A Plea for Absorbable Ligatures. H. E. Hayd, Buffalo.

19. Treatment of the Stump. J. F. Baldwin, Columbus.

20. Limitations in the Teaching of Obstetrics and Gynecology, as Determined by State Medical Examining Boards. William Warren Potter, Buffalo.

21. Subject to be announced. Walter B. Chase, Brooklyn.

22. (A.) The Philosophy of Drainage; (B) Treatment of the Pedicle in Hysterectomy or Hystero-Myomec-tomy in the Abdominal Method. George F. Hulbert, St. Louis.

23. Removal of the Uterine Appendages for Epilepsy and Insanity; a Plea for its More General Adoption. D. Tod Gillam, Columbus.

24. Albuminuria of Pregnancy. A. Fr. Eklund, Stockholm.

25. Subject to be announced. Lawson Tait, Birmingham.

26. Unnecessary and Unnatural Fixation of the Uterus and its Results. James F. W. Ross, Toronto.

27. Sarcoma of the Urethra. Charles A. L. Reed, Cincinnati.

28. Appendicitis as a Complication in Suppurative Inflammation of the Uterine Appendages. L. S. McMurtry, Louisville.

29. Gunshot Wounds of the Abdomen with the New Gun. J. D. Griffith, Kansas City.

30. Subject to be announced. Walter B. Dorsett, St. Louis.

31. Subject to be Announced. W. E. B. Davis, Birmingham.

32. Subject to be Announced. E. Arnold Praeger, Los Angeles.

33. Tubo-Ovarian Cysts, with Interesting Cases. A. Goldspohn, Chicago.

34. Obstruction of the Bowels Following Abdominal Section. George S. Peck, Youngstown.

35. Memorial of Dr. Hiram Corson. Traill Green, Easton.

Correspondence is pending concerning additional papers. All titles must be offered before August 25, when the permanent programme

goes to press. The executive council directs attention to the following by-law:

PAPERS.

VI. The titles of all papers to be read at any annual meeting shall be furnished to the secretary not later than one month before the first day of the meeting.

No paper shall be read before the association that has already been published or that has been read before any other body.

Not more than 30 minutes shall be occupied in reading any paper before the association.

Abstracts of all papers read should be furnished to the secretary at the meeting.

All papers read before the association shall become its sole property if accepted for publication, and the Executive Council may decline to publish any paper not handed to the secretary complete before the final adjournment of the annual meeting.

Dr. George Ben Johnston, 407 East Grace street, Richmond, Va., is chairman of the committee of arrangements, who should be addressed in regard to hotel accommodations and railway fares.

JOSEPH PRICE, President.

Wm. Warren Potter, Sec'y.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The date of the meeting of the Mississippi Valley Medical Association has been changed to September 15, 16, 17, 18, in order to permit the members and their families to take the opportunity accorded by this change to make a pleasant tour through the Yellowstone Park, so justly celebrated as the wonderland of America.

Prominent resident members of our association in St. Paul and Minneapolis are formulating plans for the special Yellowstone Park excursion trip, to leave on the evening of September 18, arriving in Mammoth Hot Springs, in the Yellowstone Park, about noon on the following Sunday and devoting the following five days to the wonders of this re-

markable region, returning to St. Paul Sunday, September 27.

The cost of the trip, including all expenses west of St. Paul, will be announced in due season, but we are authorized to say that the figure will be a very favorable one, and we simply wish at this time to make the preliminary announcement of this most enjoyable feature of the St. Paul meeting, so as to give members the opportunity of making their plans in advance to join the party. It is desirable that there be a party of 100 or more in order to obtain the benefit of the special train service in both directions.

It is urged that all members who desire to join the party should send their names to Dr. C. A. Wheaton, chairman of the committee of arrangements, St. Paul, at as early a date as possible.



Miscellany.

YE VILLAGE DOCTOR.

BY H. C. STEELMAN.

In the very gravest of sombre attire,
With a carriage and mein that awe
inspire,
He takes his place with the pastor
and 'squire,
Does ye Village Doctor.

In all things affecting man's estate,
Physical, moral or matters of State,
The opinions are given the greatest
weight,
Of ye Village Doctor.

No mistakes of diganosis made
Are at his sacred portals laid;
No need of criticism to be afraid,
Has ye Village Doctor.

No lengthy prescriptions in Latin ex-
pressed,
Leave patients with a sense of his
learning oppressed;
But all remedies come from the medi-
cal chest
Of ye Village Doctor.

He is sent for, has the baby the croup,

The cow the colic or the chickens the
roup—
And records each addition to the
family group,
Does ye Village Doctor.

Though saddle-bags are things of the
past,
His old gray nag and chaise still last;
And a very ovation is given as they
pass
To ye Village Doctor.

The country o'er, garden and field,
To him substantial homage yield,
Though it is not said that their ills
were healed.
By ye Village Doctor.

No social event is considered com-
plete
Unless with his presence he graces
the fete;
And strangers are given a chance to
meet
Ye Village Doctor.

What if his services be ill-paid,
And in turnips, at times, the payment
made?
The laurel crown will never fade
Of ye Village Doctor.

A TRIP TO THE SEASHORE.

One of the pleasantest trips to take
during this warm summer weather
and the most delightful way to take
it is by the South Jersey Railroad to
Cape May.

The appointments on this road are
all that can be desired; the trains
run smoothly and on account of the
use of hard coal the discomfort and
annoyance of cinders is avoided.

Cape May has the finest beach

along the coast for bathing and is
perfectly safe even for children.

Leaving Philadelphia in the morn-
ing before the heat becomes too great
and after a pleasant ride one arrives
at Cape May in time to take a de-
lightful bath in the sea before dinner,
after which, if the day only is to be
spent in this cool resort, there is
plenty of time for a walk on the beach
or a sail on the ocean and return to
Philadelphia after the intense heat
of the day is over.

Therapeutical Progress.

THE NECESSITY OF REST IN BED IN INFLUENZA.

In Dr. J. F. Goodhart's article on "Influenza," in the first volume of Dr. Thomas Clifford Allbutt's new System of Medicine, we find the following:

"There is no specific yet at hand for this disease. This is quite certain from the number of drugs that have been regarded as almost infallible by one observer and another. All are agreed, however, that mildness of attack and speedy recovery are best insured by taking at once to bed, and that it is the worst folly to struggle on with work and to attempt to fight the disease—a plan that, although some came through successfully, was, nevertheless, the cause of the loss of many lives."

—N. Y. Med. Jour.

MUSK AS A STIMULANT.

We have a remedy which, as a stimulant, is an exceedingly valuable, if neglected one. I refer to musk. I formerly regarded musk as a disgusting remnant of a barbaric pharmacopeia, but I was induced to try it in a case of enteric fever, where profound exhaustion, with subsultus, were present, and when alcoholic stimulant was refused. The result was a happy recovery, and I have had reason to think highly of the preparation in some three or four subsequent cases.

—London Med. Times.

THE CAUSATION OF GENERAL PARALYSIS.

Hirschl examined the records of 200 male cases, treated at Krafft-

Ebing's clinic, 175 of which furnished satisfactory information. Of these 56 per cent. surely, and 25 per cent. probably, had had syphilis; in 19 per cent. the evidences of preceding syphilis were not conclusive. In these latter there was an absence of any recognizable etiological factors, and the author adds that, in his experience, but 54 per cent. of the cases of late syphilis give a definite syphilitic history, which leads him to believe that general paralysis is always of specific origin.

—Neurolog Centblt.

GUAJECETIN.

Strauss (Centralbl. f. inn. Med., June 20, 1896) recommends guajecetin as a valuable agent for carrying out the creasote treatment of pulmonary tuberculosis. He has thus treated some 70 cases of phthisis in the various stages. The drug was given in doses of 0.5 g. several times in the day. Sixty-one patients took it without the least inconvenience to the digestive organs. It was well borne by six patients who had been obliged to give up the creasote treatment. Two patients complained of diminished appetite, and four others lost their appetite and had nausea and vomiting after its use, but these symptoms were in the latter cases present before the treatment was begun. Two other patients complained of pain and diarrhea, which disappeared with the discontinuance of the remedy. The same symptoms occurred after the use of creasote. Another patient complained of headache, vertigo and marked weakness on the fourth day of the treatment, these symptoms disappearing when the guajecetin was omitted. Albumen was never noted. Guajecetin has

thus certain advantages as compared with creasote. As regards its action upon the tuberculous lesions, it was impossible to distinguish the effect of the drug from that of the other therapeutic measures adopted.

NOSOPHEN IN OPHTHALMIC PRACTICE.

Hoor (*Klinische Monatsbl. f. Augenheilk.*, May, 1896) reports favorably on this substance as a substitute for iodoform. It is a compound of iodine and phenol, containing 61.7 per cent. of iodine, a brown odorless powder, insoluble in water and acids, soluble with difficulty in alcohol, more soluble in ether and chloroform, easily soluble in alkalis. It is very slightly, if at all, poisonous. When dusted on to the eye it causes no irritation, and has been employed by Hoor in the most diverse cases with favorable or not unfavorable results; as, for instance, ulcers of cornea, prolapse of iris, burns and other wounds of conjunctiva and cornea, skin wounds, etc. Even when introduced into the anterior chamber (in rabbits) it causes no irritation.

EUCAINE.

Berger (*Revue de Therap.*, June 15, 1896) has employed this drug clinically and thinks it a useful substitute for cocaine. It is but little soluble in water, but the hydrochlorate can be dissolved in water to the extent of 6 per cent. It is not so toxic as cocaine, while its anesthetic effect is fully equal to that of the latter; but whereas cocaine produces local anemia, eucaine produces local hyperemia; applied to the cornea it does not tend to produce desquamation of the superficial epithelium, which cocaine does, and it has the further advantage of not affecting the pupil or accommodation. A 1 per cent. solution applied to the eye causes no pain; a 2 per cent. solution causes some pricking. Anesthesia occurs in a few minutes; the hyperemia of the conjunctiva lasts for half an hour after the anesthesia passes off. The so-

lutions of eucaine are very stable (Vinci), and so can be easily sterilized.

HEART PAIN.

Taking consecutively a hundred cases of coarse and decided forms of disease of the heart which have been under his own immediate care, A. Ernest Samson, M. D., has found that in just half the number there was no complaint whatever of pain in any part of the chest. Seventeen referred the pain generally to the front of the chest; 15 to the back (especially between the shoulders); 12 suffered pain at the epigastrium; 11 suffered pain on the left side of the chest, while two referred their suffering to the right side. Those who localized the pain to the exact area of the heart were but eight, and of these two complained of it only after exertion. One described it as a sense of extreme soreness at the apex, while in another it partook of the character of neuralgia about the left breast. Only 8 per cent. complained of pain directly referred to the situation of the organ diseased.

—Med Rec.

THE BLADDER IN PELVIC TROUBLE.

Bladder symptoms complicate a supposed pelvic trouble in women so often that it will be found well worth while to apply local treatment in this direction. Dr. Baldy has found by long experience that such symptoms as painful micturition, frequent micturition, irritability of the bladder, bearing-down pains and bladder distress are relieved in the case of a considerable number of patients by simple dilatation of the urethra. It is, of course, presumed that these symptoms are not being produced by a positive inflammatory condition of this organ (cystitis). Even in the case of true cystitis urethral dilatation, accompanied by alkaline diuretics and bladder irrigation, is invaluable.

—Phil. Poly.

For Physicians' Wives

TO CURE HEADACHES.

A hot bath, a stroll in the fresh air, shampooing the head in weak soda water, or a timely nap in a cool, quiet room will sometimes stop a nervous headache. When overfatigued from shopping or sightseeing a sponge dipped in very hot water and pressed repeatedly over the back of the neck between the ears will be found exceedingly refreshing, especially if the face and temples are afterward subjected to the same treatment.

* * *

Neuralgia is caused not only by cold air, but by acidity of the stomach, starved nerves, imperfect teeth, or by indolence combined with a too generous diet. Heat is the best and quickest cure for this distressing pain. A hot flat-iron passed rapidly and deftly over several folds of flannel laid on the affected spot will often give relief in less than ten minutes, without the aid of medicine. Hot fomentations are of equal value; though when the skin is very tender it is more advisable to use dry heat, nothing being better for the purpose than bags of heated salt, flour or sand, which retain warmth for a long time.

* * *

Cold water, applied by the finger tips to the nerves in front of the ear, has been known to dispel neuralgic pain like magic. When caused by acidity a dose of charcoal or soda will usually act as a corrective. Sick headache is accompanied by bilious symptoms, and attacks usually come on when the person is overtired or below par physically. This is a disease of the first half of life, and often

stops of its own accord after middle age. A careful diet is imperative in every case, sweetmeats and pastry being especially pernicious.

Eating heartily when very tired, late dinners, eating irregularly, insufficient mastication or too much animal food, especially in the spring or during the hot weather, are frequent causes of indigestion, causing headaches by reflex action.

DAINTY NOVELTIES FOR THE BABY.

It has been said by one writer that "next to a bride's trousseau there is nothing so interesting to womankind as an infant's outfit."

There is nothing in all the world so pure and beautiful as a sweet baby in all its innocence and helplessness. It is by no means the most expensive and elaborate outfits that are the most artistic. Simplicity should reign here, as everywhere else.

Choose the sheerest and finest of material and have it daintily made by hand. Let the trimming consist of hemstitching, with narrow, fine lace for the neck, sleeves and trimming of yoke.

There is nothing prettier than dimities and nainsook for the little dresses.

There should be an abundance of little slips or nightgowns. A simple outfit for the little stranger consists of six dresses, six nightslips, three flannel day skirts, three flannel night skirts, three knitted shirts, three pairs of wool stockings for day wear, three pairs for night wear, four knitted or flannel bands, a flannel or ten-

nis flannel morning gown or wrapper and two little sacks.

The expense of such an outfit is slight if the garments are fashioned at home.

A cunning bassinnette, which is very inexpensive, has for its foundation a long clothes basket, covered neatly on the outside with a pretty shade of pink satine and padded inside with an old piece of quilt, and over that the pink satine. The outside has a full flounce of white dotted mull, with a little heading of the same. The inside is neatly covered with the mull and a puff finishes the edge. A wire or wicker canopy can be had for the top, and when draped with the mull over satine and finished with a large bow of pink ribbon the effect is most pleasing. A little mattress filled with curled hair is less heating than down.

Tiny sheets, hemstitched, a little pillow, with a case of sheerest linen, embroidered with an appropriate couplet, or simply the word "Baby," with an under case of satine, a white blanket with pink stripes at either end and bound with pink ribbons, and a dainty spread of white wash silk, or sheer linen, with tiny pink rosebuds embroidered on it in Asiatic filo silk, complete the furnishings of this tasteful bed. The standard is of ordinary pine, enameled white, and the basket is held in place by means of brass chains fastened to hooks.

—Home Queen.

ADVICE TO HOUSEKEEPERS.

A small hammock to be swung just over a baby's bathtub is the idea of a mother whose infant was afraid of the water. In this way it can be sponged thoroughly while lying down.

One of the best ways in which to remove old wall paper is to dip a large and clean whitewash brush in warm water and to apply it evenly to the wall before scraping with a kitchen knife. Holes in the plaster should be filled with plaster of Paris mixed with mortar.

Now is the time to prepare your potpourri for the coming winter. It is not necessary to confine yourself to rose petals alone. Leaves of the rose geranium, mignonette, violet and lemon verbena may be added to the rose petals with the layers of fine salt and a few fragrant spices.

A violet perfume may be made by putting half an ounce of arrowroot, broken into small pieces, in a bottle with two ounces of alcohol. Cork tight and shake well. After it has been standing four or five days a few drops placed on a handkerchief will leave the odor of fresh violets.

There are several ways of loosening the glass stoppers of decanters and bottles. One is to stand the bottle in hot water, another is to drop a little oil with a feather between the stopper and the decanter and to stand it near the fire. After a time strike the stopper gently with a piece of wood on all sides, and if it does not move repeat the process. A strip of flannel or wool wound around the neck of the bottle and smartly pulled backward and forward to produce friction will sometimes loosen stoppers.

A baked custard is one of the easiest things to make and also one of the easiest to spoil in baking. Place the dish containing the custard in a pan of hot water and bake in a moderate hot oven. Try it with a knife blade, and as soon as the blade comes out clean remove from the oven at once.

The sugary crust on the top of a baker's sponge cake is caused by dredging the cake thickly with powdered sugar. The reason why sponge cake is tough is often because it was baked too rapidly. Use the juice of half a lemon in it and allow a quarter of an hour for the baking.

Handkerchiefs with a very narrow hemstitched border are most desirable. There is a wave of sentiment for handkerchiefs in pale colors to wear with certain gowns, but nothing is more refined for usual wear than the white linen handkerchief, as fine as you please. The embroidered letter or monogram is small.—Boston Budget.